ADULT VOLUNTEER APPLICATION

Edward Hines, Jr. VA Hospital
5000 S. 5th Ave.
Hines, IL 60141-3030
(708) 202 - 2523

NAME _____

SOCIAL SECURITY # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

SEX MALE ____ FEMALE ____ DATE OF BIRTH _____

PHONE # WITH AREA CODE _____

NOTIFY IN CASE OF AN EMERGENCY _____ RELATIONSHIP _____

EMERGENCY PHONE # WITH AREA CODE _____

ANY ORGANIZATION AFFILIATION ? _____

HAVE YOU BEEN HOSPITALIZED AT THIS FACILITY WITHIN THE LAST 6 MONTHS?
YES ____ NO ____

DURING THE LAST 10 YEARS HAVE YOU BEEN CONVICTED OF A CRIME, BEEN IMPRISONED, BEEN ON PROBATION OR PAROLE? EXPLAIN _____

PHYSICAL LIMITATIONS – ANY HEALTH PROBLEMS _____

WHEN ARE YOU AVAILABLE? (DAYS & HOURS) _____

WHY DO YOU WANT TO VOLUNTEER AT HINES? _____

I CERTIFY THAT ALL OF MY STATEMENTS ARE TRUE, CORRECT AND COMPLETE. BY SIGNING THIS DOCUMENT, I AGREE TO A BACKGROUND CHECK. (A false statement on any part of this application is grounds for immediate dismissal.)

I hereby waive all claims to monetary benefits for services rendered a volunteer worker on a "without compensation basis". I understand that this waiver applies only to compensation for specific services rendered in the Voluntary Service Program and has no relation to any compensation for other services or benefits to which I may be entitled.

SIGNATURE OF VOLUNTEER _____ DATE _____

STUDENT VOLUNTEER PARENTAL APPROVAL

_____ has my approval and support to work as a volunteer at Hines VA Hospital.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**FOR OFFICE USE ONLY**<<<<<<<<<<<<<<<<<<<<<<<<<<<<<

I hereby appoint this applicant as a VA without compensation employee subject to the provisions of this application. The above individual has been provided basic and assignment specific orientations which have been documented in the official volunteer folder located in the VA Voluntary Service Office.

Chief, Voluntary Service _____ DATE _____

ORGANIZATION _____ SERVICE _____ ID BADGE ISSUED_____CODE _____ kdr 4/08

Edward J. Hines, Jr. Hospital
Hines, IL
Confidentiality Statement

I _____, am aware of the requirements for confidentiality. I will not divulge any information in any way to any person except in accordance with established confidentiality regulations. The penalties for unauthorized disclosure of confidential and privileged records have been explained to me.

Under Section 3305, 38 U.S.C. and VA confidentiality regulations, records and documents which are confidential and privileged information, except as authorized by established confidentiality regulations, shall be fined not more than $5,000.00 in the case of the first offense and not more than $20,000.00 in the case of each subsequent offense.

I hereby waive all claims to monetary benefits for services rendered as a volunteer worker on a "without compensation" basis. I understand that this waiver applies only to compensation for specific services rendered in the Voluntary Service Program and has no relation to any compensation for other services or benefits to which I may be entitled.

_____ _____

Signature Date

Kr 4/08

EDWARD HINES, JR. VA HOSPITAL
Voluntary Service (135)
5000 S. 5th Avenue
Hines, IL 60141-3030

NOTE TO STUDENTS AND PARENTS: The Hines VA hospital is a federal building, and, as such, must be open to the public. Our employees, patients and volunteers come from diverse backgrounds. Eligible veterans are entitled to services offered by VA, even if they have had problematic incidents in their past - unless the law specifically disqualifies them. Our job is to provide veterans care and to protect our employees, patients and volunteers as that care is provided.

STUDENT VOLUNTEER: If accepted, I agree to adhere to the policies and procedures of this VA healthcare facility and to respect the confidentiality of information pertaining to the patients and their treatment. If a patient, staff member, volunteer, and/or visitor is abusive, makes inappropriate gestures, advances or conversation, that is in a manner which makes me feel uncomfortable, I will immediately inform my supervisor or a Voluntary Service staff member.

Signature_____

Date _____

PARENT/GUARDIAN: The above named student has my consent as parent/guardian to serve as a Student Volunteer in this VA healthcare system. I have read the above agreement as signed by my student and understand their obligation to the program if they are accepted into the VAVS Student Volunteer Program. I also grant permission for my child to receive emergency medical treatment if injured while volunteering, and to have an initial and annual tuberculin skin test as required by their volunteer assignment.

Signature_____

Date _____

NOTE: Completion of this application does not guarantee acceptance into this program.

EDWARD HINES, JR. VA HOSPITAL
- HOSPITAL RULES -

YOU MUST take a Mantoux (tuberculosis) skin test prior to beginning your assignment, and ANNUALLY thereafter.

DON'T discuss or argue conversational topics, such as race, religion or politics.

DON'T interrupt anyone while in a patient's room. Any patient information **WILL NOT** be discussed with anyone.

DON'T become financially involved with a patient. This means you CANNOT handle any banking needs, including check cashing, handling of patient cash, or any other personnel banking requests.

DON'T sign wills, legal or business papers of any kind.

DON'T accept gifts, loan or borrow money to or from anyone.
DON'T allow yourself to become emotionally involved with patients. You **MUST NOT** show any partiality.

DON'T give anyone your address or phone number to anyone.

DON'T bring gifts, food, alcohol, narcotics, cigarettes or medicine to any patient.

DON'T photograph, film, video or audio tape any patient with prior written authorization.

DON'T probe or ask personnel questions, DO be a good listener, friendly, but impersonal, conduct yourself with dignity and courtesy at all times.

DO report any unusual or sudden changes in a patients condition to the ward nurse, doctor or an appropriate VA employee.

DO accept and respect any advice or suggestions from the staff, we are here to help you.

DO report any accidents or injuries to your supervisor immediately.

YOU MUST wear your identification badge **AT ALL TIMES**, while you are volunteering at this hospital. **BE PROUD** of volunteering at HINES.

All volunteer activities **MUST** be coordinated through Voluntary Service.

I HAVE READ AND UNDERSTAND THE ABOVE HINES VA HOSPITAL RULES. I ALSO UNDERSTAND THAT ANY VIOLATION OF THESE RULES IS GROUNDS FOR IMMEDIATE DISMISSAL.

_____ _____

SIGNATURE OF VOLUNTEER DATE

DO YOU PLAN TO VOLUNTEER FOR 6 MONTHS OR MORE? ____YES ____NO

Hines VA Hospital
5000 S. 5th
Hines, IL 60141

NEW VOLUNTEER MANTOUX TEST

_____	_____
VOLUNTEER NAME	DATE
_____	_____
ADDRESS	SOCIAL SECURITY
_____	_____
CITY, STATE & ZIP CODE	DATE OF BIRTH
_____	_____
PHONE # WITH AREA CODE	SEX

Employees/Volunteers are **REQUIRED** to take a tuberculin skin test prior to starting **their employment and annually thereafter.**

If the reaction is negative, a second test will be administered within two (2) weeks, except for those with written evidence of a negative Mantoux test within the previous twelve (12) months.

If the reaction is positive, a chest x-ray will be administered.

If you have a history of a previous positive Mantoux test, you will receive a chest x-ray unless evidence of a negative chest x-ray within the previous twelve (12) months is presented.

Please report with this notice to the Employee Health Section, Building 1, Room E120 any day between 8:00am and 4:30pm except Thursdays for the test. The skin test **MUST** be checked by Employee Health personnel 48 to 72 hours after being administered. If you have any questions, please call Ext. 22186. Those tests not read are invalid and will have to be repeated.

Not reporting for the annual testing may be grounds for dismissal.

TO: SUPERVISOR OF EMPLOYEE OR VOLUNTEER

DATE: _____

SUBJECT: MANTOUX TEST VERIFICATION

_____
Employee/Volunteer Name

has complied with Mantoux testing requirements.
Please file in employee/volunteer record.

_____
Employee Health Staff Signature Date

This is an OSHA mandated and hospital requirement which must be complied with on a yearly basis.

Employee Health
Office: (708) 202 – 2186
Fax: (708) 202 - 2310

HINES VA HOSPITAL
MEDICAL AUTHORIZATION

NAME OF STUDENT_____
(PLEASE PRINT NAME)

SOCIAL SECURITY NUMBER_____

History of allergy to:_____

In the event my child has a medical emergency or need for immediate care and I cannot be reached, I hereby give permission to the employee health physician or designee to provide medical care, including injections, hospitalizations, and surgery.

MY DAYTIME TELEPHONE NUMBER:_____

NAME OF PARENT/GUARDIAN:_____
(Please print name)

SIGNATURE OF PARENT/GUARDIAN:_____

The following names may be contacted in case of an emergency:

_____ _____
Name Daytime Telephone #

_____ _____
Name Daytime Telephone #

Kr 04/08

SAC

HINES VOLUNTEER

SPECIAL AGREEMENT CHECK

NAME:_____ _____ _____
(Last Name) *(First Name)* *(Middle Name)*

SSN: _____ _____**DATE OF BIRTH:**_____

ALIAS: _____ **RACE:** _____ **SEX:** _____

EYE COLOR: _____**HAIR COLOR:** _____

HEIGHT: _____ **WEIGHT:** _____

PLACE OF BIRTH: _____
(CITY & STATE / COUNTRY)

RESIDENT ADDRESS:

_____

_____
Including (STREET/CITY/STATE/ZIP CODE)

PERSONAL EMAIL ADDRESS: _____

SCHOOL EMAIL ADDRESS:_____

CITIZEN: _____**JOB TITLE:** **VOLUNTEER**

SCARS, MARKS, TATTOO(S): _____

NAME OF COLLEGE/UNIVERSITY/MEDICAL SCHOOL_____

TYPE OF APPOINTMENT ***(check one)***

_____ **Employment (Paid)** _____**Fee Basis (Consultant)** _____ **WOC** **XXXX VOLUNTEER**

_____**Intern** _____ **Resident** _____ **Work-Study** _____ **IPA** _____ **Other (specify):** _____

Kim D. Rusiecki, Voluntary Service Specialist
Signature of Appropriate Service / Service Line Official ***Date***